STATE USE ONLY
[ ] Initial Enrollment
[ ] Renewal
[ ] CHOW
[ ] Other Change

NORTH CAROLINA DIVISION OF MEDICAL ASSISTANCE
MEDICAID PARTICIPATION AGREEMENT

2501 Mail Service Center Raleigh, N.C. 27699-2501 Ph. 9l9-857-4017

_____ (_____)_____
(Business Name of Agency/Provider) (Phone No.)

_____
(Business address: Street City State Zip)

_____
(Mailing address: Street City State Zip)

_____ (_____)_____
(Name and e-mail address of contact person) (Fax No.)

A. The aforementioned provider agrees to participate in the North Carolina Medicaid Program and agrees to abide by the following terms and conditions:

1. Comply with federal and state laws, regulations, state reimbursement plan and policies governing the services authorized under the Medicaid Program and this agreement (including, but not limited to, Medicaid provider manuals and Medicaid bulletins published by the Division of Medical Assistance and/or its fiscal agent).

2. Provide services to Medicaid eligible recipients of the same quality as are provided to private paying individuals without regard to race, color, age, sex, religion, disability, or national origin.

3. Accept as payment in full, the amounts paid by the Medicaid Program except for payments from legally liable third parties and authorized cost sharing by recipients.

4. Not charge the patient or any other person for items and services covered by the Medicaid Program and to refund payments made by or on behalf of the patient for any period of time the patient is Medicaid approved, including dates for which the patient is retroactively entitled to Medicaid.

5. Maintain for a period of five (5) years from the date of service: (a) accounting records in accordance with generally accepted accounting principles and Medicaid recordkeeping requirements; and (b) other records as necessary to disclose and document fully the nature and extent of services provided and billed to the Medicaid Program. For providers who are required to submit annual cost reports, “records” include, but are not limited to, invoices, checks, ledgers, contracts, personnel records, worksheets, schedules, etc. Such records are subject to audit and review by Federal and State representatives.

6. On request, furnish to the Division of Medical Assistance (DMA) and its agents, the Centers for Medicare and Medicaid Services (CMS), or the State Medicaid Fraud Control Unit of the Attorney General's Office, any information or records, including records of any outside entities, contractors, or subcontractors for costs related to services provided to Medicaid patients and billed to the Medicaid Program.

7. Assure that items or services provided under arrangements or contracts with outside entities and professionals meet professional standards and principles and are provided promptly. Such arrangements must include provision for access and audit of records by state and federal representatives as stated in item 6 above as are necessary to establish the amounts actually billed to and collected from the provider.

8. Determine responsibility and bill all appropriate third parties prior to billing the Medicaid Program. Upon receipt of payments from third parties subsequent to reimbursement by the Medicaid Program, promptly refund such prior payments.

9. Under penalty of perjury, inform DMA of provider tax identification name, address and number at the time of enrollment and for subsequent changes and be liable for any withholding or penalties required by IRS regulations.

B. PROVIDER FURTHER UNDERSTANDS AND AGREES:

l. Payment of claims is from State, Federal and County funds and any false claims, false statements or documents, or misrepresentation or concealment of material fact may be prosecuted by applicable State and/or Federal law.

2. DMA may withhold payment because of irregularity from whatever cause until such irregularity or difference can be resolved or may recover overpayments, penalties or invalid payments due to error of the provider and/or DMA and its agents.

3. If any part of this agreement is found to be in conflict with any Federal or State laws or regulations having equal weight of law, or if any part is placed in conflict by amendment of such laws, this agreement is so amended except that if the fulfillment of this agreement on the part of either party is rendered unfeasible or impossible, both the provider and DMA shall be discharged from further obligation under the terms of this agreement, except for equitable settlement of the respective debts up to the date of termination.

4. Neither providers nor employees thereof shall use or disclose information concerning Medicaid patients, including name and address, social and economic conditions or circumstances, medical data and medical services provided, except for purposes of rendering necessary medical care, arranging for medical care or services not available from the provider, establishing eligibility of the patient, and billing for services of the provider. Neither patient records nor portions thereof may be transferred except by written consent of the patient or as otherwise provided by law.

5. That federal and/or State officials and their contractual agents may make certification and compliance surveys, inspections, medical and professional reviews, and audit of costs and data relating to services to Medicaid patients as may be necessary under Federal and State statutes, rules and regulations. Such visits must be allowed at any time during hours of operation, including unannounced visits. All such surveys, inspections, reviews and audits will be in keeping with both legal and ethical practice governing patient confidentiality.

6. That billings and reports related to services to Medicaid patients and the cost of that care must be submitted in the format and frequency specified by DMA and/or its fiscal agent.

7. That payment will be made in accordance with the approved Medicaid State Plan.

8. Neither this agreement nor the assigned provider number shall be transferable or assignable except as provided by Federal regulations.

9. This agreement may be terminated by the Provider upon giving thirty (30) days prior written notice to all parties to the agreement.

10. DMA may terminate this agreement upon giving written notice or refuse to enter into an agreement when:

    a. The provider fails to meet conditions for participation, including licensure, certification or other terms and conditions stated in the provider agreement, or

    b. The provider is determined to have violated Medicaid rules or regulations, or

    c. Any person with ownership or control interest in the provider agency or an agent or managing employee of the provider has been convicted of a criminal offense related to services provided under titles XVIII, XIX, or XX of the Social Security Act, or

    d. The provider fails to provide medically appropriate health care services, or

    e. The State determines it to be in the best interests of the State and Medicaid recipients to do so.

11. Claims may not be reassigned to an individual or organization that advances money to the provider of services for accounts receivable that the provider has assigned, sold or transferred to the individual or organization for an added fee or deduction of a portion of the accounts receivable.

C. AS A PROVIDER OF PERSONAL CARE SERVICES, THE PROVIDER CERTIFIES THAT IT COMPLIES WITH THE FOLLOWING CONDITIONS:

l. It meets the requirements as a home care agency in North Carolina under provisions of l0 NCAC Chapter 3, Subchapter L.

2. Approval to provide in-home aide services is documented in the license.

3. It meets all requirements of 42 CFR Part 455, Subpart B, regarding disclosure of ownership and control interests, disclosure of business transactions, and notification to DMA of any person with an ownership or controlling interest or any agent or managing employee who has been convicted of a criminal offense related to Titles XVIII, XIX, or XX.

4. It meets all requirements of Section 475l of the Omnibus Budget Reconciliation Act of l990 (Patient Self Determination Act) including: (i) giving patients age l8 and above, prior to beginning care of the patient, written information concerning their right to make decisions about their medical care, and to complete advance directives for their care, what the agency's policies are regarding implementation of advance directives and, (ii) conducting staff and community education on advance directives.

5. It agrees to file an amended application with DMA within 30 calendar days of a change in name, ownership or controlling interest, or IRS identifying information.

D. ELECTRONIC CLAIMS SUBMISSION:

I have read the conditions for submission of electronic claims contained in the enclosed Electronic Claims Agreement and hereby elect to:

[ ] Submit claims electronically and to abide by the conditions for electronic submission contained in the Electronic Claims Agreement.
[ ] Not submit claims electronically at this time. I understand that a separate agreement for electronic submission must be signed and approved if I subsequently elect to file claims electronically.

E. SIGNATURE OF PROVIDER:

By: _____
Signature of Authorized Agent Date

_____
Typed Name and Title of Authorized Agent

_____ _____
IRS Tax Name on W-9 IRS Number

F. EFFECTIVE DATE:

This agreement is effective _____, subject to renewal on a periodic basis, or execution of a new agreement when DMA determines that changes in law, Medicaid regulation or policies or other material circumstances so require, or by act of the parties as herein provided or by operation of law.

G. DMA APPROVAL:

Accepted on _____ by_____

(Rev. 5/00)

NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE
ELECTRONIC CLAIMS SUBMISSION (ECS) AGREEMENT

Provider Services 2501 Mail Service Center Raleigh, NC 27699-2501 Ph. 919-857-4017

The Provider of Medical Care ("Provider") under the Medicaid Program in consideration of the right to submit claims by paperless means rather than by, or in addition to, the submission of paper claims agrees that it will abide by the following terms and conditions:

l. The Provider shall abide by all Federal and State statutes, rules, regulations and policies (including, but not limited to: the Medicaid State Plan, Medicaid Manuals, and Medicaid bulletins published by the Division of Medical Assistance (DMA) and/or its fiscal agent) of the Medicaid Program, and the conditions set out in any Provider Participation Agreement entered into by and between the Provider and DMA.

2. Provider's signature electing electronic filing shall be binding as certification of Provider's intent to file electronically and its compliance with all applicable statutes, rules, regulations and policies governing electronic claims submission. The Provider agrees to be responsible for research and correction of all billing discrepancies. Any false statement, claim or concealment of or failure to disclose a material fact may be prosecuted under applicable federal and/or state law (P.L. 95-142 and N.C.G.S. 108A-63), and such violations are punishable by fine, imprisonment and/or civil penalties as provided by law.

3. Claims submitted on electronic media for processing shall fully comply with applicable technical specifications of the State of NC, its fiscal agent and/or the federal government for the submission of paperless claims. DMA or its agents may reject an entire claims submission at any time due to provider's failure to comply with the specifications or the terms of this Agreement.

4. The Provider shall furnish, upon request by DMA or its agents, documentation to ensure that all technical requirements are being met, including but not limited to requirements for program listings, tape dumps, flow charts, file descriptions, accounting procedures, and record retention.

5. The Provider shall notify DMA in writing of the name, address, and phone number of any entity acting on its behalf for electronic submission of the Provider's claims. The Provider shall execute an agreement with any such entity, which includes all of the provisions of this agreement, and Provider shall provide a copy of said agreement to DMA prior to the submission of any paperless claims by the entity. Prior written notice of any changes regarding the Provider's use of entities acting on its behalf for electronic submission of the Provider's claims shall be provided to DMA. For purposes of compliance with this agreement and the laws, rules, regulations and policies applicable to Medicaid providers, the acts and/or omissions of Provider's staff or any entity acting on its behalf for electronic submission of the Provider's claims shall be deemed those of the Provider, including any acts and/or omissions in violation of Federal and State criminal and civil false claims statutes.

6. The Provider shall have on file at the time of a claim's submission and for five years thereafter, all original source documents and medical records relating to that claim, (including but not limited to the provider's signature), and shall ensure the claim can be associated with and identified by said source documents. Provider will keep for each recipient and furnish upon request to authorized representatives of the Department of Health and Human Services, DMA, the State Auditor or the State Attorney General's Office, a file of such records and information as may be necessary to fully substantiate the nature and extent of all services claimed to have been provided to Medicaid

recipients. The failure of Provider to keep and/or furnish such information shall constitute grounds for the disallowance of all applicable charges or payments.

7. The Provider and any entity acting on behalf of the provider shall not disclose any information concerning a Medicaid recipient to any other person or organization, except DMA and/or its contractors, without the express written permission of the recipient, his parent or legal guardian, or where required for the care and treatment of a recipient who is unable to provide written consent, or to bill other insurance carriers or Medicare, or as required by State or Federal law.

8. To the extent permitted by applicable law, the Provider will hold harmless DMA and its agents from all claims, actions, damages, liabilities, costs and expenses, which arise out of or in consequence of the submission of Medicaid billings through paperless means. The provider will reimburse DMA processing fees for erroneous paperless billings when erroneous claims constitute fifty percent or more of paperless claims processed during any month. The amount of reimbursement will be the product of the per-claims processing fee paid to the fiscal agent by the State in effect at the time of submission and the number of erroneous claims in each submission. Erroneously submitted claims include duplicates and other claims resubmitted due to provider error.

9. Sufficient security procedures must be in place to ensure that all transmissions of documents are authorized and protect recipient specific data from improper access.

l0. Provider must identify and bill third party insurance and/or Medicare coverage prior to billing Medicaid.

11. Either the Provider or DMA has the right to terminate this agreement by submitting a (30) day written notice to the other party; that violation by Provider or Provider's billing agent(s) of the terms of this agreement shall make the billing privilege established herein subject to immediate revocation by DMA; that termination does not affect provider's obligation to retain and allow access to and audit of data concerning claims. This agreement is canceled if the provider ceases to participate in the Medicaid Program or if state and federal funds cease to be available.

12. No substitutions for or alterations to this agreement are permitted. In the event of change in the Provider billing number, this agreement is terminated. Election of electronic billing may be made with execution of a new provider participation agreement or completion of a separate electronic agreement.

13. Any member of a group practice that leaves the group and establishes a solo practice must make a new election for electronic billing under his solo practice provider number.

14. The cashing of checks or the acceptance of funds via electronic transfer is certification that the Provider presented the bill for the services shown on the Remittance Advice and that the services were rendered by or under the direction of the Provider.

15. Provider is responsible for assuring that electronic billing software purchased from any vendor or used by a billing agent complies with billing requirements of the Medicaid Program and shall be responsible for modifications necessary to meet electronic billing standards.

16. Electronic claims may not be reassigned to an individual or organization that advances money to the Provider for accounts receivable that the provider has assigned, sold or transferred to the individual or organization for an added fee or deduction of a portion of the accounts receivable.

SIGNATURES:

The undersigned having read this Agreement for billing Medicaid claims electronically and understanding it in its entirety, hereby agree(s) to all of the stipulations, conditions, and terms stated herein.

Provider Business Name: _____
(Must match name on remittance advice)

Site Address: _____
_____

Office Contact Person: _____ **Phone No.** (____) _____

Mailing Address: _____
_____

_____
Signature of Authorized Agent **Date**

_____
Typed or Printed Name and Title of Authorized Agent

Provider Number: _____

List of Individual Provider Names, Numbers and Signature, if Billing as a Group: (Complete for practices who will submit claims using a group provider number even if there is only one provider in the group, e.g., physicians, clinics, dentists, practitioners, etc.)

Typed Name of Provider	Attending Number	Signature

DMA APPROVAL:

Accepted effective _____ by _____

NORTH CAROLINA DIVISION OF MEDICAL ASSISTANCE

PROVIDER CERTIFICATION
FOR
SIGNATURE ON FILE

By signature below, I understand and agree that non-electronic Medicaid claims may be submitted without signature and this certification is binding upon me for my actions as a Medicaid provider, my employees, or agents who provide services to Medicaid recipients under my direction or who file claims under my provider name and identification number.

I certify that all claims made for Medicaid payment shall be true, accurate, and complete and that services billed to the Medicaid Program shall be personally furnished by me, my employees, or persons with whom I have contracted to render services, under my personal direction.

I understand that payment of claims will be from federal, state and local tax funds and any false claims, statements, or documents or concealment of a material fact may be prosecuted under applicable Federal and State laws and I may be fined or imprisoned as provided by law.

I have read and agree to abide by all provisions within the NC Medicaid provider participation agreement and/or on the back of the claim form.

SIGNATURE:

_____

Print or Type Business Name of Provider

_____

Signature of Provider Date

Group provider number to which this certification applies: _____

Attending provider number to which this certification applies: _____